PUBLIC HEALTH ETHICS: AMERICA, COVID-19, AND WHAT REMAINS UNANSWERED

by

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Abstract

Since March of 2020, the COVID-19 pandemic has continuously stretched the limits of America's institutions while wreaking collective havoc in many communities and in the lives of countless individuals. Widespread disagreements about what ought to be done to mitigate negative outcomes among political leaders and public health experts have led to various responses from local, state, and federal governments to the pandemic and its novel challenges. Indeed, leaders, and members of the public, have often disagreed about what should matter when creating COVID-19 mitigation policies. Some seek to prioritize individual liberty and promote policies that they believe would lead to economic stability, while others insist that drastic restrictions of liberty are a necessary trade-off and that the negative economic consequences of COVID-19 mitigation strategies yield to concerns of saving human life and protecting physical well-being. These tumultuous disagreements have led to a confusing barrage of policies that have had unequal negative health and social outcomes. Concerning levels of political polarization have led America's pluralistic society to entrench itself in arguments concerning what is just, fair, valuable, right, and wrong. These types of questions reside squarely within the confines of bioethics. Yet—in the wake of America's first year of coexistence with COVID-19—it appears that current bioethical frameworks are not fully equipped to adequately respond to social disputes and disagreements. This paper serves two purposes. It first points out that public health frameworks are powerful means of analyzing the ethical permissibility of policies, but that are not equipped to manage the persistent disagreements that arise when sacrificing one ethical principle for another. It then proposes the adoption of novel federal and state Health Policy Ethics

Committees, democratically elected panels who would systematically evaluate the ethical permissibility of health policies.

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Introduction

In 1979, Tom Beauchamp and Jim Childress published the first edition of *The Principles of Biomedical Ethics*. This document solidified the methodology of principlism into the field of Bioethics, in which distinct ethical principles--respect for autonomy, nonmaleficence, beneficence, and justice—are weighed and balanced.[1]

Public health as a field primarily concerns itself with promoting and protecting the health and well-being of entire populations, whereas clinical medical care focuses its attention on the health of individual patients. To be sure, the principles of autonomy, respect for persons, beneficence, nonmaleficence, and justice apply to both fields. Yet, the way in which these principles apply varies drastically when ethical analysis concerns populations instead of the individual. This being so, 21st-century authors have published frameworks that are specific to the ethics of public health. Nancy Kass's "An Ethics Framework for Public Health" (2001) encourages decision-makers to determine the effectiveness of a policy, examine and minimize the burdensomeness of those policies, ensure effective implementation, and balance benefits with burdens.[2] Understanding that promoting the health of a population is often at odds with other moral considerations, "Public Health Ethics: Mapping the Terrain," written by Childress, et. al. (2002), details a set of such general moral considerations – such as personal liberty, privacy, and confidentiality -- that public health policies may sometimes infringe upon. For such infringement to be justifiable, infringing public health policies must meet several conditions, namely that they are effective, proportionate, necessary, the least infringing option, and publicly justifiable.[3]

It is not yet clear whether decision-makers have engaged with these types of frameworks during the CVID-19 pandemic, or if they have taken seriously the kinds of ethical principles included in frameworks when forming their views or shaping their behaviors. Nonetheless, while these frameworks are both powerful and versatile tools, they lack the ability of settling broad disagreements. However, the problem is not that these tools are flawed. On the contrary, they are so useful that they create the ability for different entities to morally justify almost any reasonable action or policy—even if those two actions completely contradict one another. For example, one may believe the resolute preservation of liberty is always the correct thing to do, and therefore preferable above all else. Simultaneously, another may believe that sacrificing certain personal liberties is ethically justifiable when that reduction results in higher levels of overall population health. This is particularly true if they believe that the number of lives saved is the only consequence that is worth pursuing during a public health crisis. These two beliefs about what matters, and what ought to be done, can be held both before and after the legitimate use of an ethical framework. The worry is that ethical frameworks provide a veneer of ethical justification for ideas and proposed actions that may be highly objectionable to a minority or even a majority of other people. Consequently, something of ultimate substance remains unanswered. How do members of a pluralistic democracy make sense of disagreements, and how should health policymakers respond?

This paper is divided into six sections. Section one will present commentary on some of the many health, social, economic, and ethical implications of the COVID-19 pandemic. It will also convey the idea that the way in which a democratic society

responds to any pandemic or public health threat is inextricably connected to many factors other than epidemiology and virology alone. Section two will analyze an existing public health ethics framework and show that disagreement can persist, or be magnified, despite the use of a framework. Section three will provide a critical overview of various courses of action that societies can chart for dealing with disagreements that arise in public health policymaking. Section four will propose the creation of State and Federal Health Policy Ethics Committees (HPECs). Section five outlines the way in which HPECs should proceed with making ethical determinations about proposed health policies. Finally, section six argues that HPECs should be formed via fair and inclusive elections.

This paper will not, however, introduce a novel ethical framework that offers a specific way to weigh moral considerations or proposes a universal ethical theory. It serves as a starting point to think about disagreements in public health policy and provides just one conceivable suggestion for handling disagreement in free societies. It will attempt to remain morally and politically neutral—in so much as that is possible. Lastly, much of the reasoning contained within may be useful for any pluralistic democratic society, though many sections will discuss situations and factors that are unique to the United States experience during the first year and a half of the COVID-19 pandemic.

Section One

1.1 Health Implications of COVID-19

SARS-Cov-2 is a novel respiratory virus that was first identified in Wuhan, Hubei Province, China, during the latter part of December 2019.[4] In early 2020 the virus, and resulting disease state, Coronavirus Disease 2019 (COVID-19), quickly spread throughout the entire globe. This prompted the World Health Organization (WHO) to declare a global pandemic on March 12, 2020.[5] In summer of 2021, provisional data collected by the Centers for Disease Control's National Vital Statistics System indicate that the estimated age-adjusted death rate in the United States increased by 15.9% from 2019-2020. COVID-19 was reported as the underlying cause of death, or a contributing cause of death, for an estimated 11.3% of those deaths. Individuals who are 85 years of age or older, African Americans, Native Alaskan and American peoples, and Hispanics saw the highest age-adjusted death rates.[6] As of early-mid August 2021, a total of at least 35,983,375 Americans have contracted the SARS-COV-2 virus, and 617,704 have developed COVID-19 and died as a result.[7] COVID-19 was the third leading cause of death in The United States in 2020.[6] These mortality and morbidity numbers are some of the highest globally. They leave little doubt that America has fared very poorly in these respects.

1.2 Social, and Economic Implications of COVID-19

Shortly after the WHO declared a pandemic in March of 2020, many nations implemented various COVID-19 mitigation strategies that were meant to reduce the

spread of the contagion and prevent morbidity and mortality. In the United States, prevention measures came in the form of mandatory stay-at-home orders, strict social distancing guidelines, travel restrictions, school closures, business closures, and mandates requiring the use of facial coverings (masks) when in public areas.[8,9,10] These measures may well prevent morbidity and mortality by reducing new cases of disease and ensuring that hospitals do not fill to capacity. However, many do have an abundance of negative social and economic effects. The evidence of this is stark. In 2020, economies around the world plummeted alongside the micro-economies of local communities. Many businesses were forced to close or operate on a limited basis, and unemployment reached all-time highs.[11]

1.3 Ethics and COVID-19

The COVID-19 pandemic has come bearing many highly significant ethical trade-offs. Stay-at-home orders, for example, are likely to prevent the spread of a pathogen, and, consequently, are likely to lessen pathogen-induced morbidity and mortality in the communities where lockdowns are in effect. Importantly though, lessening the number of deaths does not automatically minimize overall harm. These types of highly restrictive mitigation strategies eliminate many of the basic freedoms that people have come to expect when living in a democratic society–such as attending spiritual gatherings, traveling, or even dining with friends and family. Fundamentally speaking, choices about how to respond to COVID-19 involve a type of decision making where some values must be prioritized at the expense of other values. Therefore, the COVID-19 pandemic is more than just a health issue. It is also an ethical one.

Section Two

In this section, I first plan to show how the Childress et al. framework could be used by two hypothetical people to analyze a particular COVID-19 mitigation policy—the mandated use of masks in public areas. Once this is done, I turn to arguing that persistent disagreement is but only one worry that should be addressed.

2.1 Understanding the Framework and its Principles

In *Public Health Ethics: Mapping the Terrain,* Childress et al. (2002) convey the idea of *general moral considerations.* At their core, these considerations are elements of morality that most reasonable people would be expected to agree with and would thereby object to having these elements infringed upon. They include producing benefits, avoiding harms, maximizing utility (producing the maximal balance of benefits over harms), procedural and distributive justice, autonomy, privacy and confidentially, disclosure of information, honesty, and trust. Public health policies typically aim at producing benefits and preventing harms but may also infringe upon other moral considerations. Childress et al. propose that when a public health policy infringes on moral considerations, it is only ethically justifiable if and when five justificatory conditions are met:

1. *Effectiveness*: Effectiveness requires showing that the policy is likely to protect public health.
2. *Proportionality:* It is essential to show that the probable public health benefits (Producing benefits, preventing harms, and maximizing utility) outweigh the infringed general moral considerations.

3. *Necessity:* Not all effective and proportionate policies are necessary to realize the public health goal that is sought. The fact that a policy will infringe of a general moral consideration provides a strong reason to seek an alternative strategy that is less morally troubling. This means that proponents of a policy must have a good faith belief, for which they can give supportable reasons, that the approach that infringes moral considerations is actually necessary
4. *Least infringement:* Even when a policy is effective, proportionate, and necessary, public health agents should seek to minimize infringement on general moral considerations. Consequently, if there are multiple policies that will meet public health goals—public health agents should implement the policy that is least infringing.
5. *Public Justification:* When public health agents believe that one of their actions, practices, or policies infringes one or more general considerations, they have a responsibility to explain and justify that infringement, whenever possible, to the relevant parties.

2.2 Using the Framework

Over the past year, disagreement, and polarized attitudes about the use of masks in public areas have been an infamous staple in American culture. This goes far beyond the point that masks are somewhat uncomfortable to wear or unpractical in some way. Many people have shown that their core values either drastically align or misalign with mask use and mask mandates. This type of disagreement is the inspiration for the characteristics of the hypothetical individuals that will be characterized below.

Our first individual is a single mother who works two jobs and attends night classes. She believes that personal freedom to act in the best interest of herself and her family is the one ethical concept that is worth promoting, regardless of all else. She has very favorable views toward individual freedom and is diametrically opposed to governmental paternalism—which she defines as overreaches into the personal lives of individuals by governmental entities. Nevertheless, she is willing to reconsider her moral values and ethical prescriptions. She accepts that many thousands of COVID-19 deaths have occurred in the US, that vulnerable populations stand to face the most harm, and that wearing a mask would possibly prevent the spread of illness.

The second individual is a person who was born in the United States to parents who immigrated from another country. However, they feel a very close connection to their heritage and the cultural values of their parents' country of origin, in which protecting collective well-being is given great importance and younger people feel a great deal of respect and admiration toward the older adults in their communities. Therefore, they feel a moral obligation to promote the greater good and protect the health and well-being of older adults. Just as our first individual, they have all the relevant facts, and can reliably interpret them. Fearing that they may have a clouded outlook on COVID-19 mask mandates, they decide to analyze their belief by using an ethical framework.

Table 1.1 is a representation of how these two individuals may use the Childress et al. framework to analyze a policy mandating the use of masks in public areas.

Table 1.1 Using an Ethics Framework

Ethical Questions	Individual One	Individual Two
Is this policy effective?	Yes and No. It is reasonable to believe that	Yes. The utility that is most meaningful is a reduction

	mask use will reduce viral spread, which will reduce morbidity and mortality. However, Masks may give people a false sense of security.	in morbidity and mortality. It seems clear that masks will reduce the instances of these events. Some people refuse to wear masks. Therefore, masks should be mandated.
Is this policy proportional?	No. Other general moral considerations, such as autonomy, are of greater moral significance than the benefits that are incurred by mask mandates.	Yes. Being forced to wear a mask when in public does not infringe on other general moral considerations in a way that is proportionate to the benefits (i.e., reduced COVID-19 morbidity and mortality) that could be gained by widespread mask use.
Is this policy a necessity?	No. There is a very meaningful difference between advising that healthy people wear a mask and mandating mask use. Given the lack of evidence that a mandate is necessary to achieve high rates of mask wearing, optional mask use for those who are healthy, and mandates for those who have tested positive, could be a sufficient approach that would still accomplish the public health goal of lessening morbidity and mortality.	Yes. Mask use prevents the spread of the Sars-CoV-2 virus. The virus has harmed of killed hundreds of thousands of Americans, and there are many people who are more likely to suffer—such as older adults and the immunocompromised. If masks are not mandated, people will not abide by recommendations to wear masks. Therefore, it is a necessity that governments use their authority to mandate mask use.
Is this the policy that produces the least Infringement on general considerations while also accomplishing public health goals?	No. Optional mask use and mask use by those who have tested positive for Sars-CoV-2 are the least restrictive measure on offer during the COVID-19 pandemic.	Yes. Sars-CoV-2 is easily spread by those who show no symptoms. Mandated mask use is not a meaningful infringement of personal autonomy. Mask use ultimately allows for an increase in personal autonomy by making

		everyday activities safer and preventing future stay-at-home or quarantine orders.
Has this policy received public justification?	No. The government, health officials, and private corporations are not trustworthy and have not been convincing with their mask mandate messaging.	Yes. The government, health officials, and private corporations have been trustworthy and transparent about why it is necessary to mandate mask use.

2.3 Further Discussion

So far, I believe I have shown that frameworks are powerful tools that can be used to justify policy making decisions when honest and informed individuals use them in appropriate ways. However, they do not attempt to compel individuals to engage with disagreement in constructive ways. Consequently, disagreement remains unaddressed.

There is also a further aspect of ethics frameworks use that has the potential to become something much ominous. In this hypothetical example, it has been stipulated that the individuals engaging with the framework are honest, reasonably informed, and do not seek to perpetuate any harm. One may positively disagree with their beliefs, but they are not harboring any animosity, and they are approaching the framework honestly. Nothing ensures that this will always be the case. A truly dishonest individual or decision maker is just as capable of using a framework, and thereby gaining a pseudo-ethical justification for a disastrous policy position. The same is true of a political actor who has a personal incentive to create policies that may be favorable to reelection hopes, or a misguided individual who is trying to legitimize a certain view in return for

fame or social status. In the hands of those that wish to ethically justify actions for bad motives, frameworks could become a means of doing so.

Section Three

As argued in the previous section, using ethics frameworks to analyze public health policies do not allow us to resolve all disagreements about those policies. In this section, I discuss other plausible ways in which disagreements could be resolved in a democratic system of government.

3.1 Ranking Moral Values

One heavy handed method of addressing the problem of moral disagreement in the context of public health policy is for the government to simply adopt and apply a systematic ranking of ethical principles where one concern will always outweigh another lesser concern in a certain situation. In the event of a pandemic, a democratic government could decide that the minimization of pathogen-induced deaths is a paramount good that it should use its power to promote. Consequently, all other ethical considerations would yield to this stated goal, and the government would try to identify that course of action that prevents the most pandemic-induced deaths. Although this method has the benefit of minimizing deaths, there are many objections that would seem to make the strategy undesirable in democratic societies. Leaving economic concerns aside, this would do nothing to solve any disagreement among the public. Instead, it recognizes that there is a presence of persistent and meaningful

disagreement and commences to enforce policies that force compliance with an agenda that is wholly unsatisfactory for some portion of a population.

3.2 Referendums

As opposed to policy makers creating and applying a ranking of ethical principles, it is also conceivable that disagreement about public health policy could be decided by means of direct democracy, for example referendums in which the public votes about specific proposed policies. On its face, it seems reasonable to conclude that referendums would identify those policies that best promote the values that the public prefers, and therefore would be the correct thing to do in a democracy. However, it is questionable whether this method is appropriate when a society is comprised of an overwhelming majority of members who are not well-informed.[12] Disinformation is rampant and is oftentimes more easily accessible than the highest quality, most recent, and most plausibly true, information on offer.[13] This type of highly politicized and polarized information space may lead to a vote that is polluted by easily falsifiable information and could ultimately cause no shortage of devastation and despair. There are also those who may remain uniformed due to being disadvantaged in a way that makes gathering this information unreasonably burdensome, or, at the least, leads many to believe that they do not have the resources such as time, access, and energy to devote to truth-seeking. For them, a vote may be based on an intuition that may or may not be justifiable in light of the actual facts of a situation. Lastly, who would be held accountable for disastrous policies if those policies were decided by referendum and what recourse could be sought?

3.3 Executive Orders and Concentrated Decision Making

Yet another way of developing health policy is to do as the United States has done during the COVID-19 pandemic—have a patchwork of conflicting policies that are decided primarily by state level executive branches of government.[14,15,16] Federalist structures of governance are often praised by those who favor the idea of keeping power and decision making somewhat smaller and closer to home. In a society as diverse as the United States, it is a given that the statistically average citizen of a conservative state is going to value a different set of policies than the average citizen of a liberal state. Some would argue that it may be better to allow states some reasonable latitude in their policymaking, and to rely on elected officials to dictate what is best for their state and those who live within its borders. This may be true of some policies, some states, and some elected officials, but it is not clear that drastic health policies should ultimately be left to a governor, and a governor alone. This is because concentrating this much authority into one office may sometimes close the door on meaningful public input and does leave vast numbers of individuals to hope that their well-being is thoughtfully and thoroughly considered by their state's governor and their team. The number of COVID-19 deaths and hospitalizations were highly variable among some states with some fairing far better than others in these two respects.[7] This means that the likelihood of experiencing a hospitalization or death from COVID-19 infections have been significantly determined by which state one resided in. If these differences had anything to do with the policy decisions of each state's governor, it follows that there should be considerable concerns about the current system of executive orders and concentrated state authority; those who are living in states that have experienced

higher rates of viral spread, morbidity, and mortality may seriously disagree with the policies that were enacted by their state's governor.

Section Four

When a decision maker accepts that persistent disagreements about health policies should is an inconvenient inevitability, and then decides to act without sufficient public input, they must also accept the inevitability of the negative consequences that those unaddressed disagreements may create. Over the course of the COVID-19 pandemic, only 42% of the public report believing that the United States government effectively handles threats to public health, and 20% percent report trusting the federal government to do the right thing. This seems to suggest that an overall lack of the government's perceived legitimacy may be present.[17] It is still too soon to tell, however, it may also be true that COVID-19 decision-making processes have led to increased polarization and lower levels of adherence. Instead of preceding in this manner, it may be far better for decision makers to begin by acknowledging that reasonable disagreement is inevitable, and then making honest attempts to develop ways to manage and reconcile disagreements that are democratic, rational, and ethical. Here I will suggest that state and federal Health Policy Ethics Committees (HPECs) are one reasonably feasible way in which public health could begin to address the reasonable disagreements that are present among members of a society. In this section, I first will draw on three other forms of ethical review and public participation in decision making to provide my rationale for the creation of HPECs, and then explain the proposed HPECs in more detail.

4.1 Internal review boards (IRBs)

IRBs are tasked with the oversight of human subjects research. They are a ubiquitous feature of academic institutions, governments, and corporations. IRBs are made up of a mix of ethics professionals, scientists, and other experts, and they regularly recruit community members to broaden their moral and ethical perspectives. HPECs would be a somewhat analogous collaboration of professionals and community members who are voted into their positions by a democratic society. The panel would have a set of procedures and rules according to which they are compelled to make judgments about specific policy decisions and these decisions would be presented to both members of the public and to those who hold positions that enable them to enact policies.

4.2 Legal System Juries

There are other analogous decision-making or advisory bodies, some of which citizens are compelled to have a part in. For example, juries serving in a court of law are tasked with reaching a decision about a specific legal question (for example, the guilt of a defendant in a criminal trial), while operating within a given set of rules and procedures. If the jury ultimately determines that someone is guilty of committing a crime, a judge is then permitted by law to use their powers to fine or imprison the guilty individual. The decisions of juries are binding on the legal system; HPECs, on the contrary, would only deliver non-binding recommendations.

4.3 Citizen Juries

Citizen juries have been used in health policy decision making in the past, for issues including consent requirements, genetic testing, placebo use, pandemic communication, and resource allocation. While they take different forms, the general concept of a citizen jury is that a group of community members is assembled and then enter an inclusive deliberative process in which proposed actions are evaluated. In most cases, the selection process for juries prioritizes the formation a demographically representative group.

Systematic reviews of past citizen juries reveal substantial overall variability in critical aspects of jury recruitment, structure, deliberation time, and facilitation.[18] This variability is troublesome in its own right because it suggests that there is not agreement about the most effective approach. For instance, 20 different types of recruitment methodologies have been identified with the majority relying on some form of random sampling while others chose members from a pool of community organizations, government departments, or existing citizens' council.[18] Choosing a group of jury members from a single community organization might very well produce different results than choosing from a random group. Those organization members are presumably interested in the same issues, may be like minded, and may already know one another. Without the incorporation of those with an opposing viewpoint, it's reasonably likely that they would automatically deliver rulings that are in favor of the causes that they have previously supported. Choosing jury members from a diverse range of organizations would be preferable. However, this method does not allow the same type of democratic participation or representation from the broader public that an inclusive election process

would create. If a jury recruiter were to have an agenda, this type of selection process would allow them to select members that they agree with or even like personally. Thus, one may argue that decision-makers did not make an honest effort to participate in deliberative democracy. Instead, they simply created a process that further legitimizes their own policy position. Random recruitment does not ensure that the jury as a whole is demographically representative of the population as a whole, nor does it ensure that the jury represents the range of values and views in the population. Jury deliberation typically ranged from 1-5 consecutive days, though one met 11 times over a 16-week period.[18] One day of deliberation on matters of health policy risks being so brief that critical nuance is lost, and members may not feel that they have enough time to express their views or seriously consider the views that are expressed by others. Some may find that 16-week deliberations are likely to be overly burdensome of the jury's time and would also note that some policy decisions must be made promptly. In terms of facilitation, previous juries have varied drastically. Some were not facilitated at all, while others used trained facilitators or were assisted by workbooks. The role of the facilitator also varied. Some facilitator roles required neutrality in so far as the content of the deliberation, but most roles were left undefined. Any of these differences could influence both the interpersonal group dynamics and the decisions of juries. A facilitator who does not remain neutral on substantive content risks introducing a level of influence that some would find objectionable. This would be especially true if a facilitator were to be tasked with delivering information to the group. These critical variations in past citizen juries could be resolved by a system of balanced oversight and the creation of standardized reasonable procedures.

4.4 State and Federal Health Policy Ethics Panel

HPECs, as proposed here, are a systematized method of receiving ethical feedback before policymakers enact policies and laws. These committees are highly analogous to citizen juries. With proper structuring, HPECs may be a system that can address many of the factors that seem to be lacking from the citizen jury process. Instituting a truly democratic election process may be capable of addressing concerns surrounding the recruitment process. Oversight and duration concerns of HPECs would be managed through a combination of instituting specific processes and having oversight teams. Finally, moderation or facilitation could be optimized by either a single federal steering committee, or individual steering committees for each state and territory, and be comprised of experts in the relevant fields of ethics, health policy, economics, and law.

The determinations that are made by HPECs would not be binding. A governor or lawmaker could choose to disregard the recommendations that are reached by HPECs. However, a decision that rejects an HPEC recommendation is anticipated to cause a need for public justification. With the HPEC system in place, two things would be true regarding public justification. Knowing that future policy decisions could be sent to an HPEC for review, decision makers would presumably give considerable amounts of thought to the ethics of those policies before they were ever made public. As a matter of process, any decision that is made that in opposition to the HPEC recommendation would require a written explanation that details why the decision-maker decided to reject an HPEC recommendation.

4.5 Structure of the HPECs

Each U.S. state and territory would have an HPEC with one federal counterpart. State and territory HPECs would consider policy decisions that are made at the state and territory level, while the federal HPEC would consider policy decisions made at the federal level.

Oversight committees and steering committees will play important roles in both the substantive and procedural elements of the HPEC process. The oversight committees are only responsible for certain procedural elements of the process, such as holding panels accountable for being present, meeting deadlines, and other administrative roles. Given that this role is not involved with any substantive processes, they could be comprised of elected officials at the state and federal levels.

The steering committee, in contrast, will be responsible for directly facilitating HPEC deliberations and potentially selecting which policies are to be reviewed. Given that this role is much more closely associated with the substantive process, I recommend that steering committee members be experts in a relevant field—such as law, ethics, medicine, or health policy. If feasible, oversight and steering committee's members could be elected. Otherwise, these members would be appointed by elected government officials.

4.6 The Role of HPECs in Future Policy Making Procedures

HPECs should not deliberate the ethical merits of *all* future health policy decisions. There are many policies that simply do not cry out for such high levels of scrutiny, and time and resources, such as money, are scarce when making health policy. If HPECs

are to be successful, there will need to be an efficient selection process that determines which policy decisions are reviewed. Policies such as mandatory hand washing for food service employees, are not ethically problematic in the way that social distancing policies can be. Washing one's hands is such an inconsequential requirement that opposing it on ethical grounds would be unreasonable. It is also perfectly sensible for decision-makers to assume that a large majority of diners would prefer that the hands which prepare their food are clean rather than unclean.

As a general recommendation, HPECs should evaluate health policies that meaningfully infringes one ethical principle in favor of promoting other ethical principles, and/or that drastically alters normal human behavior. Though, it must be said, there will inevitably be disagreement about which policies should undergo ethical review. This could be settled in at least two ways. HPECs could continuously review new policy proposals and choose which ones to review. If this were the case, the public could also be given an opportunity to formally petition the HPEC to review policy. Similarly, the public could also use the power of peaceful protest to draw attention to policies that they believe need review. Third, once HPECs and their oversight teams are formed, the initial members could decide, with as high a level of precision as possible, which types of policies that will receive future ethical review.

Section Five

This section will outline the details of HPEC procedures and decision-making processes. It also addresses the oversight and committee facilitation procedures—aspects that I believe are a necessary component of successful HPEC systems.

5.1 The Deliberative Process

HPECs discussions and deliberations should follow a prescribed deliberative process. It should be perfectly clear by now that different individuals have different opinions about any conceivable policy options, and that these differences are brought on by a host of moral views, life experiences, practicalities, and so on. On its own, disagreement is not always a negative thing. Having disagreements can sometimes lead to processes that further the discussion about what is right, wrong, or indifferent. Nonetheless, disagreement must be dealt with in a way that ensures the legitimacy of the decision-making process. This is the goal of the deliberative process outlined here. Members of the HPECs will have to prove that their opinions are reasonable, and that their disagreements are more than an exercise in confirmation bias and fallacious thinking.

5.2 Shared Facts

Understanding and agreeing on a shared understanding of reality is the first and most important prerequisite of policy evaluation and is another fundamental component of HPECs. To ensure that this crucial element of the process maintains the highest possible levels of integrity, I recommend that multiple sources present their data to an HPEC in a private setting.

Large long-standing institutions such as The World Health Organization, The Centers for Disease Control (CDC), The Food and Drug Administration (FDA), National Institutes of Health (NIH), etc. are tasked with gathering, interpreting, and disseminating the best scientific evidence available. In many cases, these bodies also provide definitive health guidance, and/or approve drug therapies. However, between February

and March of 2021, 52% of those polled during a Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health survey reported that they had “a great deal of trust” in the CDC when it comes to the recommendations that the group made to improve health. Only 37% reported that they felt a great deal of trust in the FDA and NIH.[19] These are extremely concerning statistics for various reasons. Most relevant to HPECs, the reported lack of trust in these institution’s recommendations implies that there is also a lack of trust in overall credibility. However, this data is not enough to exclude the most authoritative health institutions from the fact sharing process. Instead, to ensure that this crucial element of the process maintains the highest possible levels of integrity, I recommend that multiple sources present their data to an HPEC. This would include institutions such as those mentioned above, state, and local health departments, and independent experts who are affiliated with universities, medical centers, or reputable research bodies.

Even after the best possible evidence has been presented in a way that genuinely tries to avoid bias, scientific ambiguity may persist in some instances. HPECs will need to develop procedures for dealing with scientific uncertainty.

5.3 Structured Reasoning

One way in which a course of structured moral reasoning could begin is with open conversation and by requiring participants to keep an open mind to different moral views and assume to begin with that all moral views are equally valid. Here, each member of the panel acknowledges that all members are likely to enter a deliberation with their own set of moral and ethical beliefs. Yet, they are instructed to value the beliefs of others just

as much as their own opinions unless the shared facts of the matter directly contradict the opinions of others. It is fully permissible for one member to enter the conversation believing X action is preferable in situation Y after incorporating all of the shared facts regarding Y. It is also fully permissible for a panel member to believe Z action is preferable in situation Y after incorporating all of the shared facts regarding Y. Further, when reasoning from facts, it must be recognized as unclear whether X or Z is the correct moral or ethical belief about what should be done in response to situation Y, and one should remain open to persuasion. The same is not true of a belief about situation Y arrived at without the use of all relevant facts. In that case, the panel member's position ought to lose credibility. In other words, members should not be fully convinced that they have full possession of the moral truth until they have been given a chance to hear from others who have seen the same set of facts as they.

After this initial period of institutional skepticism, the next form of reasoning allows each member of the panel to argue for their choice of action within the scaffolding of a selected framework. I will not try to make an outright determination on which framework ought to be used or say that a new one should not be developed. However, there are many appropriate options to choose from—such as those created by the CDC's Ethics Subcommittee on Ethics, Childress, et, al. (2002) or Kass (2001). The final step in the structured reasoning process is rebuttals. Here, members are permitted to argue against specific courses of action that have been proposed by their counterparts and are free to make counterarguments to others' proposals. These counterarguments may be ones that they themselves accept or that they believe those like them would accept.

5.4 Justificatory Rationale

After the structured reasoning portion of deliberations has concluded, each ethics panel member will be required to submit a document where they have outlined their reasoning and recommendations. It will be expected that these reflections are based on the set of agreed facts and address any rebuttals that were counter to the committee member's idea about the course of action that should be pursued. A committee members should either use a specific existing ethical framework in their decision process and reasoning, or the committee member should explain why existing frameworks are not sufficient and furthermore explain how their decision process and reasoning incorporated structured ethical reflection. These documents will be open to any policymakers and the public and will serve as a map of how and why each member of the committee has made their recommendation.

5.5 Final Decision

The overall recommendation of the committee will be a product of the justificatory rationale of each member. If a majority of the committee members agree on a course of action, then the committee's final decision will reflect this majority. Members who have a different recommendation will be allowed to either dissent from the majority opinion or agree with added stipulations. After this process is complete, the committee will publish their group decision and individual rationales on a government website where it can be accessed by anyone who is interested in viewing it. In the interest of sharing the decision with as many people as possible, I recommend that there also be efforts to

share decisions via social media campaigns, media announcements, and other forms of public engagement.

5.6 Committee Oversight and Moderation

An important question is whether HPEC deliberations should be facilitated by a trained facilitator. While some might argue that facilitation could introduce bias into HPEC deliberations in some way, I conclude that facilitation is the right approach.

The goal of an HPEC facilitator is to provide a space where the deliberative process can flourish. They would be tasked with guiding the HPEC members through the deliberative process that is described above, and to interject only when it is essential—such as when and if blatant disregard for the predetermined process, abuse, introduction of false or misinformation, or any other unprofessional behavior is exhibited. This is an important element of the deliberative process because in maintains an environment in which HPEC members feel that they have an equal opportunity to participate and deliberate. The facilitator could spot any meaningful variation from the prescribed deliberative process that may be detrimental to the validity of the overall process. For example, if a panel member is either mistaken about a key fact, or is attempting to misinform another member, the facilitator would be encouraged to question this member about the source of such information.

Some may argue that it would be problematic if a facilitator were to take on a position of power within the group. For them, it may seem that the group should be completely egalitarian and that a facilitator could knowingly or unknowingly disrupt the process by interjecting their own bias or denying certain viewpoints that are expressed

by HPEC members. It is also conceivable that a facilitator could lead some HPEC members to form opinions that they wouldn't have otherwise formed without this presence in the group. For example, if a HPEC member believes that the facilitator agrees with their view, they may see this as a sign that their beliefs are correct. Conversely, a HPEC member who believes that the facilitator disagrees with them may become more defensive or less likely to voice their opinion.

While objections are of concern, ensuring that HPECs adhere to the specific deliberative process is of a higher importance. The HPEC process allows for disagreement, opposition, and value ranking. However, it does it in a way that is controlled and productive. Without a third party who can mindfully lead members through the process, and HPEC runs a serious risk of devolving into a matter of unorganized arguments where beliefs are based on false or misleading misinformation. If this is allowed to happen, the entire idea of civilized democratic participation is undermined, and HPECs would be destined to fail.

Section Six

A final issue to consider is how HPECs should be formed. As discussed above, there are multiple precedents for HPECs; for some, members are appointed, and for other members are randomly selected. I propose that HPEC members should be selected via an election process.

6.1 Why Have Elections?

In some democratic societies, elections are often openly criticized. Many claims center on an election's ability to be subject to influences such as monetary contributions, political influence, and restrictive voter rights. This leads many observers to argue for a selection process bodies that chooses random citizens for decision making roles rather than individuals who have been elected by a system that leaves much to be desired. These concerns are legitimate. However, despite the challenges that arise from a fair election process, I feel as though electing HPECs members is the best approach for two reasons. First, having the public as a whole elect HPECs members is likely the best way to ensure that HPEC deliberations reflect the range of viewpoints that are present throughout the population. Second, empowering members of the public through the HPEC election process may increase the perceived legitimacy of HPECs and their recommendations. I discuss each of these in turn, and then how HPEC election processes should be structured.

6.2 Universal Involvement Coupled with Differing Views

Health policy effects everyone. No matter what else a reasonable person cares about, they are almost certainty going to care about their health. The same is likely true about what actions one's government allows them to do and not to do. Because of this, it is vital that differing moral viewpoints of the individuals within the population are reflected in HPEC deliberations. A fair election process would make it all the more likely that HPEC deliberations reflect the range of differing moral viewpoints in the population.

6.3 Perceived Legitimacy

Just as there was disagreement between our two hypothetical people about mask mandates, there is almost certainly going to be disagreement on who should occupy seats on HPECs. One individual may believe that the appropriate HPEC member is a prominent faith leader while the other may conclude that trained experts such as epidemiologists and virologists are the ones who weigh in. The COVID-19 pandemic may have begun by stealing the first individual's job, then their vehicle, and, ultimately, their home. The other may have a family member whose chronic condition left them especially susceptible to the SARS-COV-2 virus, and after contracting COVID-19, spent weeks in an intensive care unit. Under these circumstances, it is possible to see why one would prefer an opportunity to elect someone who relates with their lived experience. In my view, acting in a way that assigns random members to a HPEC discounts the perceived legitimacy that could be gained by providing a voting opportunity to those who feel as though they have ethical values worth protecting. The same is true when unelected officials make policies without any formal public input. As such, the election process is as much about taking advantage of an opportunity to meaningfully express one's personal morality as it is about any electing any specific candidate. Finally, if a peaceful government is at all interested in high levels of policy compliance, then it is better to been seen as a legitimate force of good by those who live within its jurisdiction.

6.4 Seeking a Balanced Election Process

When designing an HPEC election process, there are several issues that need to be addressed. For example, a system would have to be in place that winnowed the field of candidates down to a manageable number. If not, it is possible that hundreds of people may run for a single election. No conceivable election process is capable of responsibly handling that many candidates and is it likely impossible that the public would be capable of meaningfully evaluating so many candidates.

One option would be that final candidates are randomly chosen from a larger applicant pool. However, choosing a final set of candidates from an initial pool of applicants sacrifices fairness and replaces it with randomness–thus possibly compromising the legitimacy of the election process. Another option is to only permit experts, or those who are knowledgeable about ethics and policy, to run; this may be slightly preferrable to random selection, though there are fairness concerns with this as well. Perhaps the answer lies in a more functional primary process that incorporates an online voting system. The candidates would be free to submit short videos that detail their points of view, CVs that outline relevant experience, and so on. There would need to be a system of fact checking that ensures the candidates are reporting honestly about their experience and expertise, and perhaps a system of checks that ensure the candidates have not committed any crimes that would disqualify them from leadership positions.

Some things are certain. For the broader election process to be fair and balanced, the process of averting an overabundance of candidates must also be fair and balanced. Otherwise, the final election would be compromised by unfairly

determining the set of eventual candidates before it even began. At the same time, elections, policymaking, and public health ethics need to be practical.

6.5 Who Should Vote?

Another challenge is who should be permitted to vote. Should the same restrictions apply to HPEC elections that apply to elections of other officials? This would exclude non-citizens, people who have been convicted of criminal felonies, those who are deemed to be mentally incapacitated, and children. As it stands, American citizens who reside in American territories are not permitted to vote in presidential elections—not to mention non-citizens, and many of those who have been convicted of a felony.[20] It just seems true that there is a floor on voting rights in America and those who are not above it do not hold the same levels of political rights that registered voters enjoy.

For each of these groups, we could ask: what is the rationale for excluding them from voting in other elections, and does this rationale apply to HPECs, given what HPECs are designed to accomplish? For the non-citizen, the reasoning for their exclusion from voting rights is based partially on a concept that citizenship is both a privilege and responsibility that may be diluted by allowing non-citizens to vote.[21] The basis for excluding those who have been convicted of felonies at least in part due to the belief that rights are dependent upon certain types of conduct, and committing a felony is the sort of conduct that disqualifies one from having the type of character that is necessary to place a reasoned vote. Another line of reasoning would condone, or even embrace, a style of retributive justice that strips voting rights as a means of

punishment.[22,23] As for children and the mentally incapacitated, it is widely argued that they lack the relevant capacities needed to competently elect representatives.

Every individual in the United States has an intimate connection with health policy. This is true regardless of their immigration status, age, criminal record, or physical or mental condition. In some cases, these vulnerable populations may even have a more intimate connection to health policy than their societal counterparts. Therefore, it is better for all able people to have a place in the processes that effect their health and wellbeing. To be clear, it is undeniable that some humans do not have the capacity to cast a vote, such as young children. A reasonable age would need to be agreed upon. However, someone who, all else equal, was not born in the United States has an equal amount of reasoning power as a citizen. The same is true of a person who has been convicted of a felony. This being so, denying them HPEC voting rights becomes a difficult position to defend.

While there are many details left to be addressed, I have made the case for a series of Health Policy Ethics Committees who would be tasked with reviewing health polices before they are implemented, whose decision-making process is guided by a deliberative process, and whose members would be elected by the public at large.

Conclusion

The COVID-19 pandemic is not over. As this is being written, debates are being had about the moral permissibility of vaccine passports, including mandatory vaccinations on college campuses and workplaces.[24,25,26] COVID-19 variants are a real concern, and they bring with them the possibility of renewed mitigation policies and allocation

strategies.[27,28] As of late July 2021, Los Angeles County became the first region to reinstate a mask mandate that requires even those who have been vaccinated to wear a mask when in public areas.[29] In addition, new CDC guidance from July 27, 2021 recommends that fully vaccinated people should mask indoors if they are located in an area with substantial or high SARS-CoV-2 transmission rates.[30] Consequently, serious thought regarding how societies ought to settle on COVID-19 policy remains relevant.

There are sure to be further difficult decisions in the coming years about public health policies of many sorts, and those decisions will have large impacts on entire populations and the individuals who comprise those populations. There will also be honest disagreement about the permissibility of these future decisions, which ethical principles matter, and which ones matter most. Some actors will always be capable of approaching frameworks with poor motives. HPECs are at least one way in which these decisions can be better informed by and responsive to the range of views held by the public. They would also serve to introduce a new level of ethical accountability for decision-makers. Finally, the HPEC election and reasoning processes that have been provided are meant to ensure that this input is legitimate. Of course, this type of increase democratic power comes with an equal increase in responsibilities for individuals. HPECs can only stand a chance at being successful if there are significant amounts of investment from the public in electing HPEC representatives with care.

Bibliography

1. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. New York: Oxford University Press; 2019.
2. Kass NE. An Ethics Framework for Public Health. Am J Public Health. 2001;91(11):1776-1782.
3. Childress JF, Faden RR, Gaare RD, et al. Public Health Ethics: Mapping the Terrain. 2002;30:9.
4. Wu F, Zhao S, Yu B, et al. A new coronavirus associated with human respiratory disease in China. Nature. 2020;579(7798):265-269. doi:10.1038/s41586-020-2008-3
5. Ciotti M, Ciccozzi M, Terrinoni A, Jiang W-C, Wang C-B, Bernardini S. The COVID-19 pandemic. Critical Reviews in Clinical Laboratory Sciences. 2020;57(6):365-388. doi:10.1080/10408363.2020.1783198
6. Ahmad FB. Provisional Mortality Data — United States, 2020. MMWR Morbidity Mortal Weekly Rep. 2021;70. doi:10.15585/mmwr.mm7014e1
7. COVID-19 Map. Johns Hopkins Coronavirus Resource Center. Accessed August 10, 2021. https://coronavirus.jhu.edu/map.html
8. Koh D. COVID-19 lockdowns throughout the world. *Occupational Medicine*. 2020;70(5):322-322. doi:10.1093/occmed/kqaa073
9. Gostin LO, Cohen IG, Koplan JP. Universal Masking in the United States: The Role of Mandates, Health Education, and the CDC. JAMA. 2020;324(9):837-838. doi:10.1001/jama.2020.15271
10. Anderson RM, Heesterbeek H, Klinkenberg D, Hollingsworth TD. How will country-based mitigation measures influence the course of the COVID-19 epidemic? *The Lancet*. 2020;395(10228):931-934. doi:10.1016/S0140-6736(20)30567-5
11. Cutler DM, Summers LH. The COVID-19 Pandemic and the $16 Trillion Virus. JAMA. 2020;324(15):1495-1496. doi:10.1001/jama.2020.19759
12. Rosen J. Americans don't know much about state government, survey finds. The Hub. Published December 14, 2018. Accessed August 10, 2021. https://hub.jhu.edu/2018/12/14/americans-dont-understand-state-government/
13. Roozenbeek J, Schneider CR, Dryhurst S, et al. Susceptibility to misinformation about COVID-19 around the world. Royal Society Open Science. 7(10):201199. doi:10.1098/rsos.201199
14. Zhang X, Warner ME. COVID-19 Policy Differences across US States: Shutdowns, Reopening, and Mask Mandates. Int J Environ Res Public Health. 2020;17(24):9520. doi:10.3390/ijerph17249520
15. Wright AL, Chawla G, Chen L, Farmer A. Tracking Mask Mandates During the Covid-19 Pandemic. *SSRN Journal*. Published online 2020. doi:10.2139/ssrn.3667149
16. Multi-State. COVID-19 Policy Tracker. Multi-State. Accessed August 10, 2021. https://www.multistate.us/issues/covid-19-policy-tracker

17. Americans' Trust in Government, Each Other, Leaders. Pew Research Center - U.S. Politics & Policy. Published July 22, 2019. Accessed March 9, 2021. https://www.pewresearch.org/politics/2019/07/22/trust-and-distrust-in-america/
18. Street J, Duszynski K, Krawczyk S, Braunack-Mayer A. The use of citizens' juries in health policy decision-making: a systematic review. Soc Sci Med. 2014;109:1-9. doi:10.1016/j.socscimed.2014.03.005
19. The Public's Perspective on the United States Public Health System. RWJF. Published May 13, 2021. Accessed August 10, 2021. https://www.rwjf.org/en/library/research/2021/05/the-publics-perspective-on-the-united-states-public-health-system.html
20. Who Can and Can't Vote in U.S. Elections | USA.Gov. Accessed August 10, 2021. https://www.usa.gov/who-can-vote
21. Kass J. It's a no-brainer: Only citizens should vote, period. chicagotribune.com. Accessed July 15, 2021. https://www.chicagotribune.com/columns/john-kass/ct-kass-immigration-met-0710-20150710-column.html
22. Arguments for and against allowing felons to vote while incarcerated. Ballotpedia. Accessed August 10, 2021. https://ballotpedia.org/Arguments_for_and_against_allowing_felons_to_vote_while_incarcerated
23. Arguments for and against automatic restoration of voting rights for convicted felons. Ballotpedia. Accessed August 10, 2021. https://ballotpedia.org/Arguments_for_and_against_automatic_restoration_of_voting_rights_for_convicted_felons
24. Skahill NT-L Samantha Lai, and Emily. Vaccine passports underscore the necessity of U.S. privacy legislation. Brookings. Published June 28, 2021. Accessed August 10, 2021. https://www.brookings.edu/blog/techtank/2021/06/28/vaccine-passports-underscore-the-necessity-of-u-s-privacy-legislation/
25. Jecker NS. Vaccine passports and health disparities: a perilous journey. Journal of Medical Ethics. Published online July 8, 2021. doi:10.1136/medethics-2021-107491
26. Gostin LO. Vaccine Mandates Are Lawful, Effective and Based on Rock-Solid Science. Scientific American. Accessed August 10, 2021. https://www.scientificamerican.com/article/vaccine-mandates-are-lawful-effective-and-based-on-rock-solid-science/
27. Planas D, Veyer D, Baidaliuk A, et al. Reduced sensitivity of SARS-CoV-2 variant Delta to antibody neutralization. Nature. Published online July 8, 2021:1-5. doi:10.1038/s41586-021-03777-9
28. Mandavilli A. C.D.C. Internal Report Calls Delta Variant as Contagious as Chickenpox. The New York Times. https://www.nytimes.com/2021/07/30/health/covid-cdc-delta-masks.html. Published July 30, 2021. Accessed August 10, 2021.
29. Craig M, Albeck-Ripka L. Wary and Weary, Los Angeles Largely Accepts Restored Mask Mandate. The New York Times. https://www.nytimes.com/2021/07/18/us/la-masks-covid.html. Published July 18, 2021. Accessed August 10, 2021.

30. CDC, Interim Public Health Recommendations for Fully Vaccinated People. Centers for Disease Control and Prevention. Published July 28, 2021. Accessed August 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html